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The Secretary of Health and Human Services sets the Medicare reimbursement rate for hospitals providing inpatient services based partly on the hospitals’ classification as urban or rural.\(^1\) Congress has twice amended the Medicare statute to allow hospitals to reclassify from urban to rural and vice-versa in order to take advantage of the benefits of those designations.\(^2\) In order to prevent hospitals from abusing the reclassification process, the Secretary promulgated a regulation known as the “Reclassification Rule,” which prohibited urban hospitals that were granted reclassification as rural hospitals

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\(^1\) See 42 U.S.C. § 1395ww (2012) (referring to payments to hospitals for inpatient hospital services). Subsection (d)(2)(D) of section 1395 defines an urban area as one within a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget, or a large urban area as one with a population of 1,000,000 people or more. \textit{Id}. The Medicare reimbursement rate for a hospital is adjusted based on the average hospital wage level in that geographic area. 42 U.S.C. § 1395ww(d)(3)(E). Thus, the reimbursement rate is affected by whether the hospital is located in a rural or urban geographic area. \textit{Id}. In 2000, MSAs were replaced by Core Based Statistical Areas (CBSA). \textit{Lawrence & Memorial Hospital v. Sebelius}, 986 F.Supp. 2d 124, 128 (D. Conn. 2013).

\(^2\) See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(h) (codified as 42 U.S.C. § 1395ww (d)(10)) (establishing the Medicare Geographic Classification Review Board (MGCRB)). Hospitals apply to the MGBRC for reclassification as urban or rural. \textit{Id}. Some hospitals in more rural areas were competing from the same labor pool as hospitals in nearby urban areas. \textit{Robert Wood Johnson Univ. Hosp. v. Thompson}, 297 F.3d 273, 276 (3d Cir. 2002). Despite competing for the same workers, the rural hospital received a lower reimbursement rate based on the wage level for that geographic area. \textit{Id}. See also Consolidated Appropriations Act of 1999, Pub. L. No. 106-113, § 401 (codified as 42 U.S.C. § 1395ww(d)(8)(E)) (allowing hospitals to change classification from urban to rural). Hospitals may want to reclassify from urban to rural under section 401 in order to access programs such as drug discount programs. 42 U.S.C. § 256b (a)(4)(O) (2012).
from then seeking reclassification back to urban in the same fiscal year.\textsuperscript{3} In \textit{Lawrence + Memorial Hospital v. Burwell}, the Second Circuit for the United States Court of Appeals considered whether the Secretary's Reclassification Rule was harmonious with Congress's intent.\textsuperscript{4} The court held that the Reclassification Rule contradicted the unambiguous language of the statute and was therefore invalid.\textsuperscript{5}

In July of 2013, Lawrence + Memorial Hospital ("Lawrence"), an urban hospital in New London, Connecticut, applied for reclassification as a rural hospital, as well as designation as a Rural Referral Center ("RCC"), which it was granted.\textsuperscript{6} Two months later, Lawrence sought reclassification as an urban hospital for wage reimbursement purposes.\textsuperscript{7} Shortly thereafter, Lawrence filed an action in district court seeking to enjoin the Secretary from applying the Reclassification Rule, which would prevent Lawrence's reclassification as an urban hospital.\textsuperscript{8} The injunction was denied, so Lawrence withdrew its status as a rural hospital and was subsequently approved for reclassification as an urban hospital.\textsuperscript{9} Lawrence then filed an amended complaint, which

\textsuperscript{3} See 42 C.F.R. § 412.230 (2014) (amended 2016) (setting out the regulations for reclassification). Subsection (a)(5)(iii) prohibits hospitals that reclassify from urban to rural from reclassifying as rural again in the same fiscal year. \textit{Id.}


\textsuperscript{5} \textit{Id.} at 267-68.

\textsuperscript{6} \textit{Id.} at 262. The Centers for Medicare and Medicaid approved both of Lawrence's applications. \textit{Id.} Designation as an RCC gave Lawrence access to favorable drug pricing through the 340B Drug Discount Program. \textit{Id.} at 260-61.

\textsuperscript{7} \textit{Id.} at 262. Lawrence was originally located in the Norwich-New London, Connecticut urban area. \textit{Id.} After Lawrence was granted a rural designation, it sought reclassification to the Nassau-Suffolk, New York urban area, which had a higher wage index and would provide the hospital with higher reimbursement rates. \textit{Id.} at 262-63. Lawrence is located over 130 miles from Nassau County. GOOGLE MAPS, https://goo.gl/maps/vsaTbreDinQ2 (last visited Mar. 3, 2017) (indicating the distance between Lawrence + Memorial Hospital and Nassau County, NY).

\textsuperscript{8} Lawrence, 812 F.3d at 263.

\textsuperscript{9} \textit{Id.} at 263. Lawrence requested cancellation of its rural status, which was granted, and thus the hospital's status as an RCC was removed. \textit{Id.} This ended Lawrence's ability to participate in the favorable drug pricing program. \textit{Id.}
alleged that the Secretary’s Reclassification Rule was invalid and sought recognition as both a rural and urban hospital.10

The district court found the statutory language ambiguous as to whether hospitals seeking reclassification as rural providers must be treated by the Secretary as rural when applying for reclassification.11 Using the Chevron test, the district court gave deference to the Secretary’s interpretation of the statute and upheld the Reclassification Rule.12 The district court held that the Secretary’s rule was not arbitrary or capricious, nor did it constitute an abuse of discretion.13 The court of appeals reversed the district court’s decision on de novo review finding that the statute’s language was unambiguous and the Secretary’s Reclassification Rule violated the intent of the statute.14

Hospitals are reimbursed for providing care to Medicare patients at varying rates, which depend partly on whether the hospital is located in a rural or urban area.15

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10 Id. Both parties moved for summary judgment on the amended complaint and the court granted the defendant’s motion. Id.
11 Lawrence, 812 F.3d at 264. The district court held that the language of the statute allowing reclassification from urban to rural was ambiguous because it “does not discuss the intersection of redesignation and geographic reclassification under the Medicare Act” and “does not address the standards by which the MGCRB should evaluate a hospital’s eligibility for geographic classification.” Id. at 263-64.
12 Id. at 263-64. See also Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984) (creating rule on how to resolve disputes over statutory meaning). A reviewing court must first determine whether a statute is ambiguous and if the language is unambiguous then the case should be decided immediately. Id. at 843. When a statute’s language is ambiguous, the court must give deference to the interpretation of the agency. Id. at 844.
13 Lawrence, 812 F.3d at 264.
14 Id. at 268. De novo review is the appropriate standard for an appeals court’s review of a lower court’s granting of a summary judgment. Id. at 264. 42 U.S.C. 1395ww(d)(8)(E) does not call for a distinction to be made between geographically rural hospitals and hospitals that achieve rural status through other means. Id. at 266. The Secretary argues that this section does not address how it will work with the MGCRB and is thus ambiguous. Id. However, the court sides with the plaintiff holding that the statute’s reference to “this subsection” refers to all of 42 U.S.C. § 1395ww, including the provisions regarding the MGCRB, and therefore requires the Secretary to treat a hospital reclassified as rural as being located in a rural area for the entirety of § 1395ww. Id.
15 See 42 U.S.C. § 1395ww(d) (2012) (setting the formula to determine reimbursement rates for hospitals accepting Medicare patients). The Secretary sets the rate based on the geographic location of the hospital as rural or urban. 42 U.S.C. § 1395ww(d)(2)(D). The rate is also adjusted
In 1989, Congress amended the Medicare Act to create a more equitable reimbursement system for rural hospitals located near large urban areas.\textsuperscript{16} Congress further amended the Medicare Act in 1999 to allow hospitals to reclassify from urban to rural in order to take advantage of certain programs available to rural hospitals.\textsuperscript{17} Concerned that

\textsuperscript{16} See Robert Wood Johnson Univ. Hosp. v. Thompson, 297 F.3d 273, 276 (3d Cir. 2002) (discussing Congress' reason for adopting the amendment to the Medicare Act). Prior to the 1989 amendment, the reimbursement rate led to some hospitals in rural areas receiving lower reimbursement rates than nearby urban hospitals even though they were competing from the same labor pool and paid similar wages. \textit{Id.} To address this inequity, Congress created the Medicare Geographic Classification Review Board. \textit{See} 42 U.S.C. § 1395ww(d)(10). Hospitals apply to the MGCRB to be reclassified from rural to urban, or vice-versa, for wage index purposes. \textit{Id.} The Secretary promulgated regulations enforcing the statute. 42 C.F.R. § 412.230 (2014) (amended 2016). The regulations set out three criteria hospitals must meet to qualify for reclassification. \textit{Id.} The hospital must demonstrate: (1) proximity to the area where it seeks reclassification; (2) that it has higher wages relative to hospitals in its current area; and (3) that it has comparable wages relative to hospitals in the area to which it seeks reclassification. \textit{Id.} The proximity requirement dictates that urban hospitals must be within fifteen miles of the area to which they seek reclassification and rural hospitals must be within thirty-five miles. \textit{Id.}

\textsuperscript{17} See 42 U.S.C. § 1395ww(d)(8)(E) (2015) (allowing hospitals to be treated as rural). In order to receive treatment as a rural, a hospital in an urban area must either: (1) be located in a rural census tract of a metropolitan statistical area; (2) be located in an area designated as rural by state law; (3) qualify as a rural referral center or sole community provider if it were located in a rural area; or, (4) meet other criteria specified by the Secretary. \textit{Id.} at § 1395ww(d)(8)(E)(ii)(I)-(IV). Hospitals treated as rural may also receive any designation available to a rural hospital, such as sole community provider or rural referral center. H.R. REP. No. 106-479, at 887 (1999) (Conf. Rep.). Among the benefits available to rural referral centers is access to discounted drugs through the 340B Drug Discount Program. 42 U.S.C. § 256b (Westlaw through Pub. L. No. 114-219). Furthermore, hospitals receiving designation as a rural referral center do not have to meet the proximity criteria or the requirement of higher wages relative to hospitals in the same geographic area. \textit{Supra} note 16 and accompanying text. \textit{See also} St. Bernard's Hosp., Inc. v. Thompson, 193 F. Supp. 2d 1097,1101-0403 (E.D. Ark. 2002) (discussing Secretary's improper interpretation of a 1997 amendment to the Medicare Act); John J. Castellani, \textit{Growth of 340B Program Triggers 'Battle Over Big Money'}, HEALIO (Aug. 25, 2014), http://www.healio.com/hematology-oncology/practice-management/news/print/hemonctoday/%7Bbafe7c5d-e4cf-43cd-882f-c3c42cc020e0%7D/growth-of-340b-program-triggers-battle-over-big-money; Andrew Pollack, \textit{Dispute Develops Over Discount Drug Program}, N.Y. TIMES (Feb. 12, 2013), http://www.nytimes.com/2013/02/13/business/dispute-develops-over-340b-discount-drug-program.html?_r=0.
hospitals would be able to take advantage of the reclassification process, the Secretary of Health and Human Services promulgated regulations aimed at preventing abuse.\textsuperscript{18}

Despite the fact that it took effect in 2000, the Reclassification Rule was not challenged in court until 2013.\textsuperscript{19} Furthermore, only two hospitals brought legal actions challenging the rule.\textsuperscript{20} In 2014, Geisinger Community Medical Center brought an action alleging that the Secretary’s Rule was unlawful.\textsuperscript{21} In that case, the Third Circuit held that the Reclassification Rule went against the unambiguous language of the statute.\textsuperscript{22} The

\textsuperscript{18} See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates, 65 Fed. Reg. 47,054-01, 47087 (Aug. 1, 2000) (to be codified at 42 C.F.R pts. 410, 412, 413 and 485) (expressing Secretary’s concern with hospitals abusing reclassification). “[W]e were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.” \textit{Id.} at 47,087-88. \textit{See also} Universal Health Servs. of McAllen, Inc. v. Sullivan, 770 F. Supp. 704, 711 (D.C. Cir. 1991) (noting that Secretary has statutory requirement to make MGCRB reclassifications budget neutral); 42 C.F.R. § 412.230 (2014) (amended 2016) (establishing the Reclassification Rule). “‘[A]n urban hospital that has been granted redesignation as rural ... cannot receive an additional reclassification by the MGCRB based on this acquired rural status for a year in which such redesignation is in effect.” Lawrence, 812 F.3d at 262 (quoting 42 C.F.R. § 412.230 (a)(5)(iii) (2014) (amended 2016)).


\textsuperscript{20} See \textit{id.} \textit{See also} Geisinger, 794 F.3d at 386. The reason for the lack of challenges to this rule may be that it affects relatively few hospitals. \textit{Supra} notes 16-17. Hospitals must meet all of the requirements in order to qualify for reclassification from urban to rural and then back to urban. \textit{Id.} Furthermore, when dealing with “complex and highly technical” regulations, like Medicare reimbursement, the regulated tend to yield to the government’s rulings. \textit{See Geisinger,} 794 F.3d at 398. However, the Reclassification Rule’s effect on the hospitals it affects is enormous, potentially in the millions of dollars. \textit{Id.} at 389.

\textsuperscript{21} \textit{Id.} at 389-90. Similar to Lawrence, Geisinger Medical Center received reclassification as a rural hospital and designation as an RRC through section 401 and further sought to reclassify to the Allentown urban area through MGCRB reclassification. \textit{Id.} at 389. Geisinger is located twenty-seven miles from the Allentown CBSA; therefore, it does not meet the proximity requirement for reclassifying, which requires urban hospitals to be located within fifteen miles of the area to which they seek reclassification. \textit{Id.} If it were not for the Reclassification Rule, Geisinger would be able reclassify to the Allentown CBSA under its acquired rural status because the proximity requirement for rural hospitals increased to thirty-five miles. \textit{See Geisinger,} 794 F.3d at 393. Furthermore, as an RRC, Geisinger would not have to meet the proximity requirement at all. \textit{Id.} However, because of the Secretary’s rule, Geisinger was forced to cancel its rural status, as well as its RRC designation, and seek reclassification to the East Stroudsburg CBSA, which lost the hospital about $1.3 million in Medicare reimbursements per year. \textit{Id.} at 389.

\textsuperscript{22} \textit{Id.} at 391.
court determined that the 1999 amendment to the Medicare Act allowed hospitals to be considered both rural and urban for the purpose of reclassification.23

In its decision, the Third Circuit cited to *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*24 The court in *Chevron* established the rules for deciding whether to give deference to an agency's interpretation of a statute.25 The first step under *Chevron* is to determine if the language of the statute is ambiguous.26 If the language is unambiguous, then the agency must promulgate regulations aligned with the clear intent of Congress.27 However, if the language is ambiguous the court gives deference to the agency interpreting the statute.28

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23 Id. at 393 (rejecting Secretary's argument that Congress did not intend for hospitals to utilize both reclassification procedures). The court held that although Congress did not expressly permit hospitals to utilize reclassification through MGCRB at the same time as seeking reclassification as rural, Congress did not expressly prohibit it either. See Geisinger, 794 F.3d at 393. The language "this subsection" was meant to cover all of § 1395ww(d), and if Congress did not want to include certain sections, they would have expressly conveyed so. Id.
24 Id. at 390-391.
26 See id. at 842-43. One must first determine if Congress has directly addressed the issue in question in the statute. Id.
27 See id. If the intent of Congress is clear, both the court and the agency must act pursuant to the intent of Congress. Id. See also *In Home Health, Inc. v. Shalala*, 188 F.3d 1043, 1047 (8th Cir. 1999) (holding that regardless of reasonableness Secretary's regulation cannot contravene the plain language of the statute); Shalala v. St. Paul-Ramsey MED. Ctr., 50 F.3d 522, 529 (8th Cir. 1995) (holding Secretary's regulations added requirements not expressly authorized by the statute).
28 *Chevron, U.S.A., Inc.*, 467 U.S. at 843. The court held:

If . . . the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id.
In Lawrence + Memorial Hospital v. Burwell, the Second Circuit came to the same conclusion on the issue as the Third Circuit.\(^{29}\) The court looked to the language of the statute authorizing hospitals to seek reclassification, as well as the legislative history.\(^{30}\) The court found that Congress clearly intended for hospitals seeking treatment as rural should be treated as rural for the purposes of the entire statute.\(^{31}\) Furthermore, the court ended the \textit{Chevron} analysis after the first step because it found the statutory language to be unambiguous.\(^{32}\) The court held that the Reclassification Rule was invalid


\(^{30}\) \textit{See supra} note 30 and accompanying text (describing the court's rationale for applying the language to the whole subsection of the statute). \textit{See also} Lawrence, 812 F.3d at 266 (reasoning that the Secretary's reading thwarted the plain meaning of the Medicare statute). The Secretary read a distinction between "geographically rural" hospitals and hospitals with "acquired rural status" into the statute that did not exist. \textit{Id.}

\(^{31}\) \textit{See supra} note 30 and accompanying text (describing the court's rationale for applying the language to the whole subsection of the statute). \textit{See also} Lawrence, 812 F.3d at 266 (reasoning that the Secretary's reading thwarted the plain meaning of the Medicare statute). The Secretary read a distinction between "geographically rural" hospitals and hospitals with "acquired rural status" into the statute that did not exist. \textit{Id.}

\(^{32}\) \textit{See supra} note 30 and accompanying text (describing the court's rationale for applying the language to the whole subsection of the statute). \textit{See also} Lawrence, 812 F.3d at 266 (refusing to challenge Congress's express intent with the Medicare statute). "[W]e hold that the text of the statute unambiguously supports Lawrence's position that the MGCRB must review reclassification applications by Section 401 hospitals according to the standards applied to hospitals geographically located in a rural area." \textit{Id.} at 264. "Since we find the statutory language to be plain and unambiguous, and at odds with the Secretary's reclassification rule . . . we have no need to engage in Step Two of the \textit{Chevron} inquiry . . . ." \textit{Id.} at 267-68. \textit{See also} L.A. Haven Hospice, Inc. v. Sebelius, 638 F.3d 644, 661 (9th Cir. 2010) (holding Secretary's regulation was not aligned with Congressional intent); Rush Univ. Med. Ctr. v. Burwell, 763 F.3d 754, 759 (7th Cir. 2014) (discussing that the Secretary should be given deference when the statute is ambiguous).
because it diverged from the meaning of the plain language of the statute. Following the decisions of the Geisinger and Lawrence courts, the Centers for Medicare and Medicaid Services along with the Secretary of Health and Human Services issued an interim final rule striking from the regulation the prohibition on hospitals seeking reclassification based on their acquired rural status.

The Second Circuit properly declared the reclassification rule invalid. Under Chevron, courts must give deference to government agencies’ interpretations of statutes when the language of the statute is ambiguous. However, when there is no ambiguity in the statute, the court must strike down an interpretation that does not adhere to the plain meaning of the statutory language. Congress spoke clearly in passing section 401 of the Consolidated Appropriations Act of 1999, unambiguously expressing their intent

33 See Lawrence, 812 F.3d at 264 (holding that Reclassification Rule violates Medicare statute). See also Rush Univ. Med. Ctr. v. Burwell, 763 F.3d at 760.
34 See Medicare Program; Temporary Exception for Certain Severe Wound Discharges from Certain Long-Term Care Hospitals Required by the Consolidated Appropriations Act, 2016; Modification of Limitations on Redesignation by the Medicare Geographic Classification Review Board, 81 Fed. Reg. 23428 (effective Apr. 21, 2016) (to be codified at 42 C.F.R. pt. 412). An interim final rule is published by an agency in situations when there is cause to forego the notice and comment period normally required in the rulemaking process. See Office of the Federal Register, A Guide to the Rulemaking Process, FEDERALREGISTER.GOV, https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf (last visited Mar. 3, 2017). In the interim final rule published by HHS, the agency recognized the decisions in Geisinger and Lawrence invalidated the Reclassification Rule. See 81 Fed. Reg. 23428, supra. The interim final rule reads:

While these decisions currently apply only to hospitals located within the jurisdictions of the Second and Third Circuits, we believe that maintaining the regulations at § 214.230(a)(5)(ii) in other places nationally would constitute inconsistent application of reclassification policy based on jurisdictional regions. In the interest of creating a uniform national reclassification policy, we are removing the regulation text . . .

Id.
35 See Lawrence, 812 F.3d at 268; See also id. at 264 n.4 (noting Second Circuit joins Third Circuit in holding that HHS Secretary's interpretation violates Medicare statute).
37 Id. at 843. See also Lawrence, 812 F.3d. 257
that hospitals receiving rural status under the law must be treated as rural for all purposes of subsection (d) of the Medicare statute.\textsuperscript{38} Using the \textit{Chevron} analysis, courts have similarly struck down other regulations promulgated by the Secretary of Health and Human Services.\textsuperscript{39}

The Secretary of Health and Human Services chose to follow the decision of the courts and abolish the rule.\textsuperscript{40} However, the Secretary has valid concerns regarding the abuse of the reclassification system as established by Congress.\textsuperscript{41} If the Secretary wanted to keep the rule in place she could have amended the regulation to align it with

\textsuperscript{38} \textit{See Lawrence}, 812 F. 3d at 266.
\textsuperscript{39} \textit{See St. Bernard's Hosp., Inc. v. Thompson}, 193 F. Supp. 2d 1097 (E.D. Arkansas, 2002) (holding that Secretary's rule denying of RRC status to hospitals seeking reclassification was invalid). In 1997 Congress passed an amendment to the Medicare Act that stated in part that all hospitals designated as RRC's prior to 1991 must be allowed to maintain such designation. \textit{Id.} at 1102-03. However, the Secretary failed to enact Congress' intent until section 401 was passed in 1999, at which point the Secretary revisited its ruling. \textit{Id.} Therefore, according to the court, certain hospitals were wrongfully denied their privileges as RRC's for the years in which the statute was improperly interpreted. \textit{Id. See also L.A. Haven Hospice, Inc. v. Sebelius}, 638 F.3d 644 (9th Cir. 2010) (holding statutory language was unambiguous and the Secretary's regulation did not align with Congressional intent). \textit{But see} Rush Univ. Med. Ctr. v. Burwell, 763 F.3d 754 (7th Cir. 2014) (stating when a statute leaves room for interpretation the agency's interpretation must be given deference).

\textsuperscript{40} \textit{See} 81 Fed. Reg. 23428, \textit{supra} note 34.
\textsuperscript{41} \textit{See Lawrence}, 812 F.3d 257, 260-61 (2d. Cir. 2016). Hospitals that receive RRC designation, including those that achieve rural status through reclassification, have better access to programs such as the 340B Drug Discount Program. \textit{Id.} RRCs only need a disproportionate share adjustment percentage of low income patients of eight percent whereas other non-RRC hospitals must have a percentage of 11.75. \textit{Id. See also John J. Castellani, Growth of 340B Program Triggers 'Battle Over Big Money', HEALIO} (Aug. 25, 2014), http://www.healio.com/hematology-oncology/practice-management/news/print/hemonc-today/%7Bbafc7c5d-e4cf-43cd-882f-c3c42cc020c0%7D/growth-of-340b-program-triggers-battle-over-big-money. (last visited Mar. 3, 2017). Some hospitals are able to take advantage of the 340B program for financial gain at the expense of health care prices. \textit{Id. See also Andrew Pollack, Dispute Develops Over Discount Drug Program}, N.Y. TIMES (Feb. 12, 2013), http://www.nytimes.com/2013/02/13/business/dispute-develops-over-340b-discount-drug-program.html?_r=0. (last visited Mar. 3, 2017). The program provides hospitals with discounted drugs to treat poor patients; however, the hospitals can also treat Medicare and privately insured patients with the drugs and pocket the difference in the discounted price and the full reimbursement received. \textit{Id. See also Universal Health Services of McAllen, Inc. v. Sullivan}, 770 F. Supp. 704, 711 (D.D.C. 1991) (noting that Secretary has statutory requirement to make all reclassifications budget neutral).
Congress’ intent but still prevent abuse by hospitals. For example, the Secretary could have eliminated regulations giving special treatment to rural referral centers making it easier for them to receive reclassification to an urban area though the MGCRB. The Secretary could also have followed a policy of nonacquiescence towards the court’s rulings. By doing this, the Secretary would refuse to apply the courts’ rulings to other hospitals, though it would still be bound to follow the ruling of the courts for the parties to the litigation.

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42 See supra note 18 and accompanying text (noting the Secretary is concerned hospitals will abuse the system). Congress directed the Secretary to ensure all reclassifications by hospitals are budget neutral. 42 U.S.C. 1395ww(d)(8)(D) (discussing inpatient hospital service payments on basis of prospective rates); Universal Health Servs. of McAllen, 770 F. Supp. at 711 (noting “the Secretary has an obligation to . . . ensure budget neutrality for that fiscal year.”). The Secretary is required to make proportional adjustments to reimbursement rates for urban hospitals in order to ensure a reclassification does not lead to aggregate payments being made that are greater or less than those that would otherwise be made. 42 U.S.C. 1395ww(d)(8)(D). Therefore, a hospital taking advantage of reclassification to a rural area under subsection (d)(8)(E), then attempting to reclassify through the MGCRB with all of the benefits afforded to rural hospitals places the Secretary’s budget neutrality in jeopardy and affects the rates of other urban hospitals that cannot take advantage of the process. See supra note 18 and accompanying text. However, as the court in Universal Health Services of McAllen noted, the Secretary’s difficulty in ensuring budget neutrality does not allow him to violate federal law. Universal Health Servs. of McAllen, 770 F. Supp. at 711.

43 42 C.F.R. § 412.230(a)(3) (2014) (amended 2016). For example, without the Reclassification Rule, Geisinger Medical Center will be able to reclassify to Allentown CBSA, which is twenty-seven miles away, using the Secretary’s regulation that exempts RRCs from the proximity requirement when reclassifying to an urban area. Supra note 21 and accompanying text. By eliminating this exemption, Geisinger will not receive special treatment. Supra note 21 and accompanying text. However, this regulation is meant to aid hospitals originally designated as RRCs and not just those that receive designation through reclassification under subsection (d)(8)(E) of the statute. C.F.R. § 412.230(a)(3) (2014) (amended 2016). Based on the language of the statute, any regulation affecting the rights of hospitals with acquired rural status would also necessarily affect geographically located rural hospitals. 42 U.S.C. § 1395ww(d)(8)(E). The Secretary may not want to harm all RRCs to prevent potential abuse by a few. See Geisinger Cmty. Med. Ctr., 794 F.3d 383, 387 (describing relaxed standards for rural hospitals).

44 See W. Gordon Dobie, Nonacquiescence: Health and Human Services’ Refusal to Follow Federal Court Precedent, 63 WASH. U. L. REV. 737, 737 (1985) (describing the doctrine of nonacquiescence). “Nonacquiescence is an administrative agency’s refusal to follow federal court decisions in subsequent cases.” Id.

45 See id. See also S & H Riggers & Erectors, Inc. v. Occupational Safety & Health Review Comm’n, 659 F.2d 1273 (5th Cir. 1981). The court in S & H states:
If the Secretary chose nonacquiescence and did not to amend the regulation, then the result would have been an increase in litigation from hospitals across the country seeking to apply for reclassification as urban after having received a reclassification to rural in the same year, but being barred from doing so by the Reclassification Rule. Continued nonacquiescence and application of the rule by the Secretary would potentially have resulted in endless litigation, unless the Supreme Judicial Court heard an appeal to a circuit court’s ruling. The passing of Justice Antonin Scalia has left the future of the Court in question. Depending on the ideology of Scalia’s replacement they may be more or less likely to give deference to the

panel, however, does not have that freedom but must follow the precedent set by prior panels of the Fifth Circuit until and unless they are reversed by the court en banc or by the Supreme Court.

Id. at 1278-79.

46 See Lawrence, 812 F.3d at 259. Following the decisions of the Second and Third Circuits, any hospital similarly situated to Lawrence or Geisinger can now proceed with confidence in an action challenging the Secretary’s rule. See id.; Geisinger, 794 F.3d at 395.

47 See Dobie, supra note 44, at 738.

Administrative agencies rationalize the policy of nonacquiescence in a number of ways. First, agencies insist that nonacquiescence provides uniform application of nationwide programs. Second, agencies claim that nonacquiescence is necessary to fulfill their responsibility to manage federal programs. Third, agencies assert that nonacquiescence promotes equal treatment of litigants throughout the country. Fourth, agencies allege that nonacquiescence and relitigation create intercircuit conflict, prompting Supreme Court review.

Id. If another circuit disagrees with the holdings of the Second and Third Circuit Courts, then such a circuit split might lead to the issue coming before the Supreme Court. Id. See also Ben James, 2nd Cir. To Wait For High Court In Dodd-Frank Battle, LAW360 (Oct. 15, 2015, 8:43 PM), http://www.law360.com/articles/714711/2nd-circ-to-wait-for-high-court-in-dodd-frank-battle (describing circuit split regarding validity of SEC regulation of Dodd-Frank law). The Supreme Court has the authority to declare a ruling for all courts in the country when circuits disagree about the validity of an agency regulation. Id.

Secretary’s rule. In the absence of clarification by the Secretary, there would also be a question of how hospitals affected by the Reclassification Rule would react to the courts’ decisions. They could have continued to challenge the regulation circuit by circuit, or if a hospital successfully challenged the regulation in the U.S. Court of Appeals for the District of Columbia Circuit there would be an opening for all hospitals to subsequently bring actions to the D.C. Circuit where they would be guaranteed a favorable decision. In order to avoid the possibility of further litigation and uncertainty in the application of regulations, the Secretary chose the best solution of following the ruling of the courts and removing the troublesome regulation.


50 See supra note 46 and accompanying text.

51 See supra note 41. Venue -- Government Officers And Agencies As Defendants, U.S. Attorney’s Manual, DEP’T OF JUSTICE, https://www.justice.gov/usam/civil-resource-manual-41-venue-government-officers-and-agencies-defendants (last visited Mar. 3, 2017). An action against a government agent may be brought in the jurisdiction where “a defendant in the action resides.” Id. The residence of the agent is considered to be the location where their official duties are performed. Id. For the Secretary of Health and Human Services this is the District of Columbia. Lawrence, 812 F.3d at 257. A person may also bring an action in the location where the events giving rise to the action took place. U.S. Attorney’s Manual supra. For a hospital bringing an action, this would be the jurisdiction where the hospital is located. Lawrence, 812 F.3d at 257. Therefore, if one hospital is successful in challenging the Reclassification Rule in the District of Columbia all hospitals will have the option of bringing an action to the same court. Id.

52 See 81 Fed. Reg. 23428, supra note 34 (amending regulation to allow hospitals nationwide to reclassify as rural). If Congress decides that it agrees with the Secretary’s original Reclassification Rule and seeks to prevent potential abuse by hospitals of the reclassification system, then
The decisions in the Second and Third Circuits to strike down the Secretary of Health and Human Services' Reclassification Rule created uncertainty among hospitals across the nation regarding how this regulation will now be applied. If the Secretary decided to insist on enforcing the regulation, hospitals will be forced to litigate in order to access the reclassification apparatus provided to them in statute. Nonacquiescence to the courts' rulings by the Secretary would have resulted in excessive litigation that will not be ultimately decided upon until the Supreme Court rules on the validity of the regulation. The decision by the Secretary to adhere to the ruling of the courts prevented this uncertainty from continuing.

Congress can enact a new statute giving the Secretary authority to promulgate regulations barring hospitals that receive rural reclassification from then seeking reclassification to urban through the MGCRB process. See Ruger, supra note 30 at 337 (discussing aftermath of FDA v. Brown & Williamson). Nine years after the court struck down the FDA's regulations of tobacco products for not adhering to Congressional intent, Congress rewrote the statute to give the FDA authority to regulate tobacco products. Id.

See supra note 18. See 65 Fed. Reg. 47,054, 47,087 (expressing Secretary's concern with hospitals abusing reclassification).

See supra note 32 and accompanying text (positing that the MGCRB must review reclassification applications by Section 401 hospitals).

See supra note 45 and accompanying text (illustrating an agency's refusal to follow federal court decisions in subsequent cases).

See supra note 34 (discussing Secretary's decision following courts' decisions).